STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
OFFICE OF BENEFIT DETERMINATION
DISABILITY EVALUATION UNIT

Date: _____

TO: Presiding Workers' Comp. Judge, _____
(Office)

FROM: Disability Evaluation Unit, _____
(Office)

SUBJECT: DEU File:

Employee:

QME:

Date of Report:

The attached formal medical evaluation apportions the permanent disability. Please determine whether the apportionment is valid.

If you refer the report back to the medical evaluator for correction or clarification, and you receive no response within 30 days, please make a determination based on the available evidence.

Please indicate whether the apportionment is consistent with the law by checking the appropriate space, sign and date the bottom of this form and return it with the medical report to the DEU office listed above.

Thank you.

The apportionment: IS CONSISTENT _____ or

IS NOT CONSISTENT _____ with the law.

_____ , **Workers' Compensation Judge**
(Signature)

_____
(Date)

NOTE: This memorandum is an administrative document and is not admissible in any judicial proceeding.

DEU Form 105 (Rev 3-91)